A bill for an act

relating to human services; changing health care eligibility provisions; making changes to individualized education plan requirements; state health access program; children's health insurance reauthorization act; long-term care partnership; asset transfers; community clinics; dental benefits; prior authorization for health services; drug formulary committee; preferred drug list; multisource drugs; administrative uniformity committee; health plans; claims against the state; amending Minnesota Statutes 2008, sections 62A.045; 62Q.80; 62S.24, subdivision 8; 256B.055, subdivision 10; 256B.057, subdivision 1; 256B.0571, subdivision 6; 256B.0625, subdivisions 13c, 13g, 25, 30, by adding a subdivision; Minnesota Statutes 2009 Supplement, sections 15C.13; 256B.0571, subdivision 8; 256B.0625, subdivisions 9, 13e, 26; proposing coding for new law in Minnesota Statutes, chapter 62S; repealing Minnesota Statutes 2008, sections 256B.0571, subdivision 10; 256B.0595, subdivisions 1b, 2b, 3b, 4b, 5.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

ARTICLE 1

INDIVIDUALIZED EDUCATION PLAN SERVICES

Section 1. Minnesota Statutes 2009 Supplement, section 256B.0625, subdivision 26, is amended to read:

Subd. 26. **Special education services.** (a) Medical assistance covers medical services identified in a recipient's individualized education plan and covered under the medical assistance state plan. Covered services include occupational therapy, physical therapy, speech-language therapy, clinical psychological services, nursing services, school psychological services, school social work services, personal care assistants serving as management aides, assistive technology devices, transportation services, health assessments, and other services covered under the medical assistance state plan. Mental health services eligible for medical assistance reimbursement must be provided or

coordinated through a children's mental health collaborative where a collaborative exists if the child is included in the collaborative operational target population. The provision or coordination of services does not require that the individual education plan be developed by the collaborative.

The services may be provided by a Minnesota school district that is enrolled as a medical assistance provider or its subcontractor, and only if the services meet all the requirements otherwise applicable if the service had been provided by a provider other than a school district, in the following areas: medical necessity, physician's orders, documentation, personnel qualifications, and prior authorization requirements. The nonfederal share of costs for services provided under this subdivision is the responsibility of the local school district as provided in section 125A.74. Services listed in a child's individual education plan are eligible for medical assistance reimbursement only if those services meet criteria for federal financial participation under the Medicaid program.

(b) Approval of health-related services for inclusion in the individual education plan does not require prior authorization for purposes of reimbursement under this chapter. The commissioner may require physician review and approval of the plan not more than once annually or upon any modification of the individual education plan that reflects a change in health-related services.

(c) Services of a speech-language pathologist provided under this section are covered notwithstanding Minnesota Rules, part 9505.0390, subpart 1, item L, if the person:

(1) holds a masters degree in speech-language pathology;

(2) is licensed by the Minnesota Board of Teaching as an educational speech-language pathologist; and

(3) either has a certificate of clinical competence from the American Speech and Hearing Association, has completed the equivalent educational requirements and work experience necessary for the certificate or has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(d) Medical assistance coverage for medically necessary services provided under other subdivisions in this section may not be denied solely on the basis that the same or similar services are covered under this subdivision.

(e) The commissioner shall develop and implement package rates, bundled rates, or per diem rates for special education services under which separately covered services are grouped together and billed as a unit in order to reduce administrative complexity.

(f) The commissioner shall develop a cost-based payment structure for payment of these services. Only costs reported through the designated Minnesota Department of Education data systems qualify for inclusion in the cost-based payment structure. The

commissioner shall reimburse claims submitted based on an interim rate, and shall settle at a final rate once the department has determined it. The commissioner shall notify the school district of the final rate. The school district has 60 days to appeal the final rate. To appeal the final rate, the school district shall file a written appeal request to the commissioner within 60 days of the date the final rate determination was mailed. The appeal request shall specify (1) the disputed items and (2) the name and address of the person to contact regarding the appeal.

(g) Effective July 1, 2000, medical assistance services provided under an individual education plan or an individual family service plan by local school districts shall not count against medical assistance authorization thresholds for that child.

(h) Nursing services as defined in section 148.171, subdivision 15, and provided as an individual education plan health-related service, are eligible for medical assistance payment if they are otherwise a covered service under the medical assistance program. Medical assistance covers the administration of prescription medications by a licensed nurse who is employed by or under contract with a school district when the administration of medications is identified in the child's individualized education plan. The simple administration of medications alone is not covered under medical assistance when administered by a provider other than a school district or when it is not identified in the child's individualized education plan.

ARTICLE 2

STATE HEALTH ACCESS PROGRAM

Section 1. Minnesota Statutes 2008, section 62Q.80, is amended to read:

62Q.80 COMMUNITY-BASED HEALTH CARE COVERAGE PROGRAM.

Subdivision 1. **Scope.** (a) ~~A~~ Any community-based health care initiative may develop and operate ~~a~~ community-based health care coverage ~~program~~ programs that ~~offers~~ offer to eligible individuals and their dependents the option of purchasing through their employer health care coverage on a fixed prepaid basis without meeting the requirements of chapter 60A, 62A, 62C, 62D, 62M, 62N, 62Q, ~~or~~ 62T, or 62U, or any other law or rule that applies to entities licensed under these chapters.

(b) ~~The~~ Each initiative shall establish health outcomes to be achieved through the ~~program~~ programs and performance measurements in order to determine whether these outcomes have been met. The outcomes must include, but are not limited to:

(1) a reduction in uncompensated care provided by providers participating in the community-based health network;

(2) an increase in the delivery of preventive health care services; and

(3) health improvement for enrollees with chronic health conditions through the management of these conditions.

In establishing performance measurements, the initiative shall use measures that are consistent with measures published by nonprofit Minnesota or national organizations that produce and disseminate health care quality measures.

(c) Any program established under this section shall not constitute a financial liability for the state, in that any financial risk involved in the operation or termination of the program shall be borne by the community-based initiative and the participating health care providers.

Subd. 1a. **Demonstration project.** The commissioner of health and the commissioner of human services shall award ~~a~~ demonstration project ~~grant~~ grants to ~~a~~ community-based health care ~~initiative~~ initiatives to develop and operate ~~a~~ community-based health care coverage ~~program to operate within Carlton, Cook, Lake, and St. Louis Counties~~ programs in Minnesota. The demonstration ~~project~~ projects shall extend for five years and must comply with the requirements of this section.

Subd. 2. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Community-based" means located in or primarily relating to the community ~~of geographically contiguous political subdivisions~~, as determined by the board of a community-based health initiative that is served by the community-based health care coverage program.

(b) "Community-based health care coverage program" or "program" means a program administered by a community-based health initiative that provides health care services through provider members of a community-based health network or combination of networks to eligible individuals and their dependents who are enrolled in the program.

(c) "Community-based health initiative" or "initiative" means a nonprofit corporation that is governed by a board that has at least 80 percent of its members residing in the community and includes representatives of the participating network providers and employers, or a county-based purchasing organization as defined in section 256B.692.

(d) "Community-based health network" means a contract-based network of health care providers organized by the community-based health initiative to provide or support the delivery of health care services to enrollees of the community-based health care coverage program on a risk-sharing or nonrisk-sharing basis.

(e) "Dependent" means an eligible employee's spouse or unmarried child who is under the age of 19 years.

Subd. 3. **Approval.** (a) Prior to the operation of a community-based health care coverage program, a community-based health initiative, defined in subdivision 2, paragraph (c), and receiving funds from the Department of Health, shall submit to the commissioner of health for approval the community-based health care coverage program developed by the initiative. Each community-based health initiative as defined in subdivision 2, paragraph (c), and receiving State Health Access Program (SHAP) grant funding shall submit to the commissioner of human services for approval prior to its operation the community-based health care coverage programs developed by the initiatives. The ~~commissioner~~ commissioners shall ensure that ~~the~~ each program meets the federal grant requirements and any requirements described in this section and is actuarially sound based on a review of appropriate records and methods utilized by the community-based health initiative in establishing premium rates for the community-based health care coverage ~~program~~ programs.

(b) Prior to approval, the commissioner shall also ensure that:

(1) the benefits offered comply with subdivision 8 and that there are adequate numbers of health care providers participating in the community-based health network to deliver the benefits offered under the program;

(2) the activities of the program are limited to activities that are exempt under this section or otherwise from regulation by the commissioner of commerce;

(3) the complaint resolution process meets the requirements of subdivision 10; and

(4) the data privacy policies and procedures comply with state and federal law.

Subd. 4. **Establishment.** The initiative shall establish and operate upon approval by the ~~commissioner~~ commissioners of health ~~a~~ and human services community-based health care coverage ~~program~~ programs. The operational structure established by the initiative shall include, but is not limited to:

(1) establishing a process for enrolling eligible individuals and their dependents;

(2) collecting and coordinating premiums from enrollees and employers of enrollees;

(3) providing payment to participating providers;

(4) establishing a benefit set according to subdivision 8 and establishing premium rates and cost-sharing requirements;

(5) creating incentives to encourage primary care and wellness services; and

(6) initiating disease management services, as appropriate.

Subd. 5. **Qualifying employees.** To be eligible for the community-based health care coverage program, an individual must:

(1) reside in or work within the designated community-based geographic area served by the program;

(2) be employed by a qualifying employer ~~or,~~ be an employee's dependent, or be self-employed on a full-time basis;

(3) not be enrolled in or have currently available health coverage, except for catastrophic health care coverage; and

(4) not be eligible for or enrolled in medical assistance~~,~~ or general assistance medical care, and not be enrolled in MinnesotaCare~~,~~ or Medicare.

Subd. 6. **Qualifying employers.** (a) To qualify for participation in the community-based health care coverage program, an employer must:

(1) employ at least one but no more than 50 employees at the time of initial enrollment in the program;

(2) pay its employees a median wage ~~of $12.50 per hour~~ that equals 350 percent of the federal poverty guidelines or less; and

(3) not have offered employer-subsidized health coverage to its employees for at least 12 months prior to the initial enrollment in the program. For purposes of this section, "employer-subsidized health coverage" means health care coverage for which the employer pays at least 50 percent of the cost of coverage for the employee.

(b) To participate in the program, a qualifying employer agrees to:

(1) offer health care coverage through the program to all eligible employees and their dependents regardless of health status;

(2) participate in the program for an initial term of at least one year;

(3) pay a percentage of the premium established by the initiative for the employee; and

(4) provide the initiative with any employee information deemed necessary by the initiative to determine eligibility and premium payments.

Subd. 7. **Participating providers.** Any health care provider participating in the community-based health network must accept as payment in full the payment rate established by the ~~initiative~~ initiatives and may not charge to or collect from an enrollee any amount in access of this amount for any service covered under the program.

Subd. 8. **Coverage.** (a) The ~~initiative~~ initiatives shall establish the health care benefits offered through the community-based health care coverage ~~program~~ programs. The benefits established shall include, at a minimum:

(1) child health supervision services up to age 18, as defined under section 62A.047; and

(2) preventive services, including:

(i) health education and wellness services;

(ii) health supervision, evaluation, and follow-up;

(iii) immunizations; and

(iv) early disease detection.

(b) Coverage of health care services offered by the program may be limited to participating health care providers or health networks. All services covered under the ~~program~~ programs must be services that are offered within the scope of practice of the participating health care providers.

(c) The ~~initiative~~ initiatives may establish cost-sharing requirements. Any co-payment or deductible provisions established may not discriminate on the basis of age, sex, race, disability, economic status, or length of enrollment in the ~~program~~ programs.

(d) If any of the ~~initiative~~ initiatives amends or alters the benefits offered through the program from the initial offering, ~~the~~ that initiative must notify the ~~commissioner~~ commissioners of health and human services and all enrollees of the benefit change.

Subd. 9. **Enrollee information.** (a) The ~~initiative~~ initiatives must provide an individual or family who enrolls in the program a clear and concise written statement that includes the following information:

(1) health care services that are ~~provided~~ covered under the program;

(2) any exclusions or limitations on the health care services ~~offered~~ covered, including any cost-sharing arrangements or prior authorization requirements;

(3) a list of where the health care services can be obtained and that all health care services must be provided by or through a participating health care provider or community-based health network;

(4) a description of the program's complaint resolution process, including how to submit a complaint; how to file a complaint with the commissioner of health; and how to obtain an external review of any adverse decisions as provided under subdivision 10;

(5) the conditions under which the program or coverage under the program may be canceled or terminated; and

(6) a precise statement specifying that this program is not an insurance product and, as such, is exempt from state regulation of insurance products.

(b) The ~~commissioner~~ commissioners of health and human services must approve a copy of the written statement prior to the operation of the program.

Subd. 10. **Complaint resolution process.** (a) The ~~initiative~~ initiatives must establish a complaint resolution process. The process must make reasonable efforts to resolve complaints and to inform complainants in writing of the initiative's decision within 60 days of receiving the complaint. Any decision that is adverse to the enrollee shall include a description of the right to an external review as provided in paragraph (c) and how to exercise this right.

(b) The ~~initiative~~ initiatives must report any complaint that is not resolved within 60 days to the commissioner of health.

(c) The ~~initiative~~ initiatives must include in the complaint resolution process the ability of an enrollee to pursue the external review process provided under section 62Q.73 with any decision rendered under this external review process binding on the ~~initiative~~ initiatives.

Subd. 11. **Data privacy.** The ~~initiative~~ initiatives shall establish data privacy policies and procedures for the program that comply with state and federal data privacy laws.

Subd. 12. **Limitations on enrollment.** (a) The ~~initiative~~ initiatives may limit enrollment in the program. If enrollment is limited, a waiting list must be established.

(b) The ~~initiative~~ initiatives shall not restrict or deny enrollment in the program except for nonpayment of premiums, fraud or misrepresentation, or as otherwise permitted under this section.

(c) The ~~initiative~~ initiatives may require a certain percentage of participation from eligible employees of a qualifying employer before coverage can be offered through the program.

Subd. 13. **Report.** ~~(a) The~~ Each initiative shall submit quarterly status reports to the commissioner of health on January 15, April 15, July 15, and October 15 of each year, with the first report due January 15, 2008. ~~The~~ Each initiative receiving funding from the Department of Human Services shall submit status reports to the commissioner of human services as defined in the terms of contract with the Department of Human Services. Each status report shall include:

(1) the financial status of the program, including the premium rates, cost per member per month, claims paid out, premiums received, and administrative expenses;

(2) a description of the health care benefits offered and the services utilized;

(3) the number of employers participating, the number of employees and dependents covered under the program, and the number of health care providers participating;

(4) a description of the health outcomes to be achieved by the program and a status report on the performance measurements to be used and collected; and

(5) any other information requested by the ~~commissioner~~ commissioners of health, human services, or commerce or the legislature.

~~(b) The initiative shall contract with an independent entity to conduct an evaluation of the program to be submitted to the commissioners of health and commerce and the legislature by January 15, 2010. The evaluation shall include:~~

~~(1) an analysis of the health outcomes established by the initiative and the performance measurements to determine whether the outcomes are being achieved;~~

~~(2) an analysis of the financial status of the program, including the claims to premiums loss ratio and utilization and cost experience;~~

~~(3) the demographics of the enrollees, including their age, gender, family income, and the number of dependents;~~

~~(4) the number of employers and employees who have been denied access to the program and the basis for the denial;~~

~~(5) specific analysis on enrollees who have aggregate medical claims totaling over $5,000 per year, including data on the enrollee's main diagnosis and whether all the medical claims were covered by the program;~~

~~(6) number of enrollees referred to state public assistance programs;~~

~~(7) a comparison of employer-subsidized health coverage provided in a comparable geographic area to the designated community-based geographic area served by the program, including, to the extent available:~~

~~(i) the difference in the number of employers with 50 or fewer employees offering employer-subsidized health coverage;~~

~~(ii) the difference in uncompensated care being provided in each area; and~~

~~(iii) a comparison of health care outcomes and measurements established by the initiative; and~~

~~(8) any other information requested by the commissioner of health or commerce.~~

Subd. 14. **Sunset.** This section expires ~~December 31, 2012~~ August 31, 2014.

ARTICLE 3

CHILDREN'S HEALTH INSURANCE REAUTHORIZATION ACT (CHIPRA)

Section 1. Minnesota Statutes 2008, section 256B.055, subdivision 10, is amended to read:

Subd. 10. **Infants.** Medical assistance may be paid for an infant less than one year of age, whose mother was eligible for and receiving medical assistance at the time of birth ~~and who remains in the mother's household~~ or who is in a family with countable income that is equal to or less than the income standard established under section 256B.057, subdivision 1.

Sec. 2. Minnesota Statutes 2008, section 256B.057, subdivision 1, is amended to read:

Subdivision 1. **Infants and pregnant women.** (a)(1) An infant less than one year of age or a pregnant woman who has written verification of a positive pregnancy test from a physician or licensed registered nurse is eligible for medical assistance if countable family income is equal to or less than 275 percent of the federal poverty guideline for the

same family size. For purposes of this subdivision, "countable family income" means the amount of income considered available using the methodology of the AFDC program under the state's AFDC plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, except for the earned income disregard and employment deductions.

(2) For applications processed within one calendar month prior to the effective date, eligibility shall be determined by applying the income standards and methodologies in effect prior to the effective date for any months in the six-month budget period before that date and the income standards and methodologies in effect on the effective date for any months in the six-month budget period on or after that date. The income standards for each month shall be added together and compared to the applicant's total countable income for the six-month budget period to determine eligibility.

(b)(1) [Expired, 1Sp2003 c 14 art 12 s 19]

(2) For applications processed within one calendar month prior to July 1, 2003, eligibility shall be determined by applying the income standards and methodologies in effect prior to July 1, 2003, for any months in the six-month budget period before July 1, 2003, and the income standards and methodologies in effect on the expiration date for any months in the six-month budget period on or after July 1, 2003. The income standards for each month shall be added together and compared to the applicant's total countable income for the six-month budget period to determine eligibility.

(3) An amount equal to the amount of earned income exceeding 275 percent of the federal poverty guideline, up to a maximum of the amount by which the combined total of 185 percent of the federal poverty guideline plus the earned income disregards and deductions allowed under the state's AFDC plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA), Public Law 104-193, exceeds 275 percent of the federal poverty guideline will be deducted for pregnant women and infants less than one year of age.

(c) Dependent care and child support paid under court order shall be deducted from the countable income of pregnant women.

(d) An infant born ~~on or after January 1, 1991,~~ to a woman who was eligible for and receiving medical assistance on the date of the child's birth shall continue to be eligible for medical assistance without redetermination until the child's first birthday~~, as long as the child remains in the woman's household~~.

ARTICLE 4

LONG-TERM CARE PARTNERSHIP

Section 1. Minnesota Statutes 2008, section 62S.24, subdivision 8, is amended to read:

Subd. 8. **Exchange for long-term care partnership policy; addition of policy rider.** (a) ~~If authorized by federal law or a federal waiver is granted~~ With respect to the long-term care partnership program referenced in section 256B.0571, issuers of long-term care policies may voluntarily exchange a current long-term care insurance policy for a long-term care partnership policy that meets the requirements of Public Law 109-171, section 6021, after the effective date of the state plan amendment implementing the partnership program in this state. The exchange may be in the form of: (1) an amendment or rider; or (2) a disclosure statement indicating that the coverage is now partnership qualified.

(b) ~~If authorized by federal law or a federal waiver is granted~~ With respect to the long-term care partnership program referenced in section 256B.0571, ~~allowing~~ to allow an existing long-term care insurance policy to qualify as a partnership policy by addition of: (1) a policy rider, or amendment; or (2) a disclosure statement, the issuer of the policy is authorized to add the rider, amendment, or disclosure statement to the policy after the effective date of the state plan amendment implementing the partnership program in this state.

(c) The commissioner, in cooperation with the commissioner of human services, shall pursue any federal law changes or waivers necessary to allow the implementation of paragraphs (a) and (b).

Sec. 2. **[62S.312] CONSUMER PROTECTION STANDARDS FOR LONG-TERM CARE PARTNERSHIP POLICIES.**

To qualify as a long-term care partnership policy under this chapter, long-term care insurance policies must meet the requirements for being tax qualified as defined in section 7702B(b) of the Internal Revenue Code and meet certain consumer protection requirements in Section 6021(a)(1)(B)(5)(A) of the Deficit Reduction Act of 2005, Public Law 109-171, which are taken from the National Association of Insurance Commissioners (NAIC) Model Act and Regulation of 2000. Insurance carriers must certify for each policy form to be included in the long-term care partnership that the form complies with the requirements of the NAIC Model Act and Regulation of 2000 as implemented in sections 62S.05 to 62S.11; 62S.13 to 62S.18; 62S.19; 62S.20, subdivisions 1 to 5; 62S.21; 62S.22; 62S.24; 62S.25; 62S.266; 62S.28; 62S.29; 62S.30; and 62S.31.

Sec. 3. Minnesota Statutes 2008, section 256B.0571, subdivision 6, is amended to read:

Subd. 6. **Partnership policy.** "Partnership policy" means a long-term care insurance policy that meets the ~~requirements under subdivision 10 and~~ criteria in sections 62S.23, subdivision 1, paragraph (b), and 62S.312 and was issued on or after ~~the effective date of the state plan amendment implementing the partnership program in Minnesota. Policies that are exchanged or that have riders or endorsements added on or after the effective date of the state plan amendment as authorized by the commissioner of commerce qualify as a partnership policy~~ July 1, 2006, or exchanged on or after July 1, 2006, under the provisions of section 62S.24, subdivision 8.

Sec. 4. Minnesota Statutes 2009 Supplement, section 256B.0571, subdivision 8, is amended to read:

Subd. 8. **Program established.** (a) The commissioner, in cooperation with the commissioner of commerce, shall establish the Minnesota partnership for long-term care program to provide for the financing of long-term care through a combination of private insurance and medical assistance.

(b) An individual becomes eligible to participate in the partnership program by meeting the requirements of either clause (1) or (2):

(1) the individual may qualify as a beneficiary of a partnership policy that ~~either (i) is issued on or after the effective date of the state plan amendment implementing the partnership plan in Minnesota, or (ii) qualifies as a partnership policy as authorized by the commissioner of commerce~~ meets the criteria under subdivision 6. To be eligible under this clause, the individual must be a Minnesota resident at the time coverage first became effective under the partnership policy; or

(2) the individual may qualify as a beneficiary of a policy recognized under subdivision 17.

Sec. 5. **REPEALER.**

Minnesota Statutes 2008, section 256B.0571, subdivision 10, is repealed.

ARTICLE 5

MODIFICATION TO PROHIBITIONS ON ASSET TRANSFERS

Section 1. **REPEALER.**

Minnesota Statutes 2008, section 256B.0595, subdivisions 1b, 2b, 3b, 4b, and 5, are repealed.

ARTICLE 6

COMMUNITY CLINICS

Section 1. Minnesota Statutes 2008, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, public health clinic services~~, and the services of a clinic meeting the criteria established in rule by the commissioner~~. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. A federally qualified health center that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, a federally qualified health center shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. Federally qualified health centers that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), a federally qualified health center or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the Department of Health according to section 62Q.19, subdivision 7. For those federally qualified health centers and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For federally qualified health centers and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable

to the same service provided by health care providers that are not federally qualified health centers or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring a federally qualified health center or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

(e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

(f) Effective January 1, 2001, each federally qualified health center and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) For purposes of this section, "nonprofit community clinic" is a clinic that:

(1) has nonprofit status as specified in chapter 317A;

(2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

(3) is established to provide health services to low-income population groups, uninsured, high-risk and special needs populations, underserved and other special needs populations;

(4) employs professional staff at least one-half of which are familiar with the cultural background of their clients;

(5) charges for services on a sliding fee scale designed to provide assistance to low-income clients based on current poverty income guidelines and family size; and

(6) does not restrict access or services because of a client's financial limitations or public assistance status and provides no-cost care as needed.

ARTICLE 7

DENTAL BENEFIT SET

Section 1. Minnesota Statutes 2009 Supplement, section 256B.0625, subdivision 9, is amended to read:

Subd. 9. **Dental services.** (a) Medical assistance covers dental services.

(b) Medical assistance dental coverage for nonpregnant adults is limited to the following services:

(1) comprehensive exams, limited to once every five years;

(2) periodic exams, limited to one per year;

(3) limited exams;

(4) bitewing x-rays, limited to one per year;

(5) periapical x-rays;

(6) panoramic x-rays, limited to one every five years~~, and only if provided in conjunction with a posterior extraction or scheduled outpatient facility procedure, or as~~ except (1) when medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma~~. Panoramic x-rays may be taken~~ or (2) once every two years for patients who cannot cooperate for intraoral film due to a developmental disability or medical condition that does not allow for intraoral film placement;

(7) prophylaxis, limited to one per year;

(8) application of fluoride varnish, limited to one per year;

(9) posterior fillings, all at the amalgam rate;

(10) anterior fillings;

(11) endodontics, limited to root canals on the anterior and premolars only;

(12) removable prostheses, each dental arch limited to one every six years;

(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;

(14) palliative treatment and sedative fillings for relief of pain; and

(15) full-mouth debridement, limited to one every five years.

(c) In addition to the services specified in paragraph (b), medical assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:

(1) periodontics, limited to periodontal scaling and root planing once every two years;

(2) general anesthesia; and

(3) full-mouth survey once every five years.

(d) Medical assistance covers medically necessary dental services for children ~~that are medically necessary~~ and pregnant women. The following guidelines apply:

(1) posterior fillings are paid at the amalgam rate;

(2) application of sealants are covered once every five years per permanent molar for children only; ~~and~~

(3) application of fluoride varnish is covered once every six months~~.~~; and

(4) orthodontia is eligible for coverage for children only.

ARTICLE 8

PRIOR AUTHORIZATION FOR HEALTH SERVICES

Section 1. Minnesota Statutes 2008, section 256B.0625, subdivision 25, is amended to read:

Subd. 25. **Prior authorization required.** ~~The commissioner shall publish in the State Register a list of health services that require prior authorization, as well as the criteria and standards used to select health services on the list. The list and the criteria and standards used to formulate it are not subject to the requirements of sections 14.001 to 14.69.~~ The commissioner's decision whether prior authorization is required for a health service is not subject to administrative appeal.

ARTICLE 9

DRUG FORMULARY COMMITTEE

Section 1. Minnesota Statutes 2008, section 256B.0625, subdivision 13c, is amended to read:

Subd. 13c. **Formulary committee.** The commissioner, after receiving recommendations from professional medical associations and professional pharmacy associations, and consumer groups shall designate a Formulary Committee to carry out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be comprised of four licensed physicians actively engaged in the practice of medicine in Minnesota one of whom must be actively engaged in the treatment of persons with mental illness; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer representative; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the Formulary Committee shall not be employed by the Department of Human Services, but the committee shall be staffed by an employee of the department who shall serve as an ex officio, nonvoting member of the committee. The department's medical director shall also serve as an ex officio, nonvoting member for the committee. Committee members shall serve three-year terms and may be reappointed by the commissioner. The Formulary Committee shall meet at least ~~quarterly~~ biannually. The commissioner may require more frequent Formulary Committee meetings as needed. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance.

ARTICLE 10

PREFERRED DRUG LIST

Section 1. Minnesota Statutes 2008, section 256B.0625, subdivision 13g, is amended to read:

Subd. 13g. **Preferred drug list.** (a) The commissioner shall adopt and implement a preferred drug list by January 1, 2004. The commissioner may enter into a contract with a vendor for the purpose of participating in a preferred drug list and supplemental rebate program. The commissioner shall ensure that any contract meets all federal requirements and maximizes federal financial participation. The commissioner shall publish the preferred drug list annually in the State Register and shall maintain an accurate and up-to-date list on the agency Web site.

(b) The commissioner may add to, delete from, and otherwise modify the preferred drug list, after consulting with the Formulary Committee and appropriate medical specialists and providing public notice and the opportunity for public comment.

(c) The commissioner shall adopt and administer the preferred drug list as part of the administration of the supplemental drug rebate program. Reimbursement for prescription drugs not on the preferred drug list may be subject to prior authorization~~, unless the drug manufacturer signs a supplemental rebate contract~~.

(d) For purposes of this subdivision, "preferred drug list" means a list of prescription drugs within designated therapeutic classes selected by the commissioner, for which prior authorization based on the identity of the drug or class is not required.

(e) The commissioner shall seek any federal waivers or approvals necessary to implement this subdivision.

ARTICLE 11

MULTISOURCE DRUGS

Section 1. Minnesota Statutes 2009 Supplement, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical

assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. Effective July 1, 2009, the actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus 15 percent. The actual acquisition cost of antihemophilic factor drugs shall be estimated at the average wholesale price minus 30 percent. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(c) Whenever a ~~generically equivalent product is available~~ maximum allowable cost has been set for a multisource drug, payment shall be on the basis of ~~the actual acquisition cost of the generic drug, or on~~ the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.

(d) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the

provider or the amount established for Medicare by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act.

(e) The commissioner may negotiate lower reimbursement rates for specialty pharmacy products than the rates specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

ARTICLE 12

ADMINISTRATIVE UNIFORMITY COMMITTEE

Section 1. Minnesota Statutes 2008, section 256B.0625, is amended by adding a subdivision to read:

Subd. 8d. **Home infusion therapy services.** Home infusion therapy services provided by home infusion therapy pharmacies must be paid the lower of the submitted charge or the combined payment rates for component services typically provided.

EFFECTIVE DATE. This section is effective upon federal approval.

Sec. 2. Minnesota Statutes 2009 Supplement, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus

the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. Effective July 1, 2009, the actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus 15 percent. The actual acquisition cost of antihemophilic factor drugs shall be estimated at the average wholesale price minus 30 percent. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(c) Whenever a generically equivalent product is available, payment shall be on the basis of the actual acquisition cost of the generic drug, or on the maximum allowable cost established by the commissioner.

(d) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider or the amount established for Medicare by the United States Department of

Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act.

(e) The commissioner may negotiate lower reimbursement rates for specialty pharmacy products than the rates specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

(f) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

EFFECTIVE DATE. This section is effective upon federal approval.

ARTICLE 13

HEALTH PLANS

Section 1. Minnesota Statutes 2008, section 62A.045, is amended to read:

62A.045 PAYMENTS ON BEHALF OF ENROLLEES IN GOVERNMENT HEALTH PROGRAMS.

(a) As a condition of doing business in Minnesota or providing coverage to residents of Minnesota covered by this section, each health insurer shall comply with the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171, including any federal regulations adopted under that act, to the extent that it imposes a requirement that applies in this state and that is not also required by the laws of this state. This section does not require compliance with any provision of the federal act prior to the effective date provided for that provision in the federal act. The commissioner shall enforce this section.

For the purpose of this section, "health insurer" includes self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are by contract legally responsible to pay a claim for a healthcare item or service for an individual receiving benefits under paragraph (b).

(b) No ~~health~~ plan offered by a health insurer issued or renewed to provide coverage to a Minnesota resident shall contain any provision denying or reducing benefits because services are rendered to a person who is eligible for or receiving medical benefits pursuant to title XIX of the Social Security Act (Medicaid) in this or any other state; chapter 256; 256B; or 256D or services pursuant to section 252.27; 256L.01 to 256L.10; 260B.331, subdivision 2; 260C.331, subdivision 2; or 393.07, subdivision 1 or 2. No health ~~carrier~~ insurer providing benefits under plans covered by this section shall use eligibility for medical programs named in this section as an underwriting guideline or reason for nonacceptance of the risk.

(c) If payment for covered expenses has been made under state medical programs for health care items or services provided to an individual, and a third party has a legal liability to make payments, the rights of payment and appeal of an adverse coverage decision for the individual, or in the case of a child their responsible relative or caretaker, will be subrogated to the state agency. The state agency may assert its rights under this section within three years of the date the service was rendered. For purposes of this section, "state agency" includes prepaid health plans under contract with the commissioner according to sections 256B.69, 256D.03, subdivision 4, paragraph (c), and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; and county-based purchasing entities under section 256B.692.

(d) Notwithstanding any law to the contrary, when a person covered by a ~~health~~ plan offered by a health insurer receives medical benefits according to any statute listed in this section, payment for covered services or notice of denial for services billed by the provider must be issued directly to the provider. If a person was receiving medical benefits through the Department of Human Services at the time a service was provided, the provider must indicate this benefit coverage on any claim forms submitted by the provider to the health carrier for those services. If the commissioner of human services notifies the health carrier that the commissioner has made payments to the provider, payment for benefits or notices of denials issued by the health carrier must be issued directly to the commissioner. Submission by the department to the health carrier of the claim on a

Department of Human Services claim form is proper notice and shall be considered proof of payment of the claim to the provider and supersedes any contract requirements of the health carrier relating to the form of submission. Liability to the insured for coverage is satisfied to the extent that payments for those benefits are made by the health carrier to the provider or the commissioner as required by this section.

(e) When a state agency has acquired the rights of an individual eligible for medical programs named in this section and has health benefits coverage through a health carrier, the health carrier shall not impose requirements that are different from requirements applicable to an agent or assignee of any other individual covered.

~~(f) For the purpose of this section, health plan includes coverage offered by community integrated service networks, any plan governed under the federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, sections 1001 to 1461, and coverage offered under the exclusions listed in section 62A.011, subdivision 3, clauses (2), (6), (9), (10), and (12).~~

ARTICLE 14

CLAIMS AGAINST THE STATE

Section 1. Minnesota Statutes 2009 Supplement, section 15C.13, is amended to read:

15C.13 DISTRIBUTION TO PRIVATE PLAINTIFF IN CERTAIN ACTIONS.

If the prosecuting attorney intervenes at the outset in an action brought by a person under section 15C.05, the person is entitled to receive not less than 15 percent or more than 25 percent of any recovery in proportion to the person's contribution to the conduct of the action. If the prosecuting attorney does not intervene in the action at any time, the person is entitled to receive not less than 25 percent or more than 30 percent of any recovery of the civil penalty and damages, or settlement, as the court determines is reasonable. If the prosecuting attorney does not intervene in the action at the outset but subsequently intervenes, the person is entitled to receive not less than 15 percent or more than 30 percent of any recovery, as the court determines is reasonable based on the person's participation in the action before the prosecuting attorney intervened. For recoveries whose distribution is governed by federal code or rule, the basis for calculating the portion of the recovery the person is entitled to receive shall not include amounts reserved for distribution to the federal government or designated in their use by federal code or rule.

APPENDIX
Article locations in 10-4246

256B.0571 LONG-TERM CARE PARTNERSHIP PROGRAM.

Subd. 10. **Long-term care partnership policy inflation protection.** A long-term care partnership policy must provide the inflation protection described in this subdivision. If the policy is sold to an individual who:

(1) has not attained age 61 as of the date of purchase, the policy must provide compound annual inflation protection;

(2) has attained age 61, but has not attained age 76 as of such date, the policy must provide some level of inflation protection; and

(3) has attained age 76 as of such date, the policy may, but is not required to, provide some level of inflation protection.

256B.0595 PROHIBITIONS ON TRANSFER; EXCEPTIONS.

Subd. 1b. **Prohibited transfers.** (a) Notwithstanding any contrary provisions of this section, this subdivision applies to transfers involving recipients of medical assistance that are made on or after July 1, 2003, and to all transfers involving persons who apply for medical assistance on or after July 1, 2003, if the transfer occurred within 72 months before the person applies for medical assistance, except that this subdivision does not apply to transfers made prior to July 1, 2003. A person, a person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or the person's spouse, may not give away, sell, dispose of, or reduce ownership or control of any income, asset, or interest therein for less than fair market value for the purpose of establishing or maintaining medical assistance eligibility. This applies to all transfers, including those made by a community spouse after the month in which the institutionalized spouse is determined eligible for medical assistance. For purposes of determining eligibility for medical assistance services, any transfer of such income or assets for less than fair market value within 72 months before or any time after a person applies for medical assistance may be considered. Any such transfer is presumed to have been made for the purpose of establishing or maintaining medical assistance eligibility, and the person is ineligible for medical assistance services for the period of time determined under subdivision 2b, unless the person furnishes convincing evidence to establish that the transaction was exclusively for another purpose or unless the transfer is permitted under subdivision 3b or 4b.

Convincing evidence of any one of the following facts shall establish that a gift that is a charitable contribution to an organization described in section 170(c) of the Internal Revenue Code of 1986, as amended, was made exclusively for a purpose other than establishing or maintaining medical assistance eligibility, unless at the time of the gift the donor or donor's spouse was receiving long-term care services, was advised by a medical professional of the need for long-term care services, or was a medical assistance applicant or recipient:

(1) the donor made one or more gifts to the same donee organization more than 180 days prior to the date of the gift in question; or

(2) the gift was made to an organization for which the donor had provided volunteer services, acknowledged in writing by the organization, prior to the date of the gift.

A person may alternatively establish with other convincing evidence that a charitable gift was made exclusively for a purpose other than establishing or maintaining medical assistance eligibility.

(b) This section applies to transfers to trusts. The commissioner shall determine valid trust purposes under this section. Assets placed into a trust that is not for a valid purpose shall always be considered available for the purposes of medical assistance eligibility, regardless of when the trust is established.

(c) This section applies to transfers of income or assets for less than fair market value, including assets that are considered income in the month received, such as inheritances, court settlements, and retroactive benefit payments or income to which the person or the person's spouse is entitled but does not receive due to action by the person, the person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or the person's spouse.

(d) This section applies to payments for care or personal services provided by a relative, unless the compensation was stipulated in a notarized written agreement that was in existence when the service was performed, the care or services directly benefited the person, and the payments made represented reasonable compensation for the care or services provided. A notarized written agreement is not required if payment for the services was made within 60 days after the service was provided.

(e) This section applies to the portion of any income, asset, or interest therein that a person, a person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or the person's spouse, transfers to any annuity that exceeds the value of the benefit likely to be returned to the person or the person's spouse while alive, based on estimated life expectancy, using the life expectancy tables employed by the supplemental security income program, or based on a shorter life expectancy if the annuitant had a medical condition that would shorten the annuitant's life expectancy and that was diagnosed before funds were placed into the annuity. The agency may request and receive a physician's statement to determine if the annuitant had a diagnosed medical condition that would shorten the annuitant's life expectancy. If so, the agency shall determine the expected value of the benefits based upon the physician's statement instead of using a life expectancy table. This section applies to an annuity described in this paragraph purchased on or after March 1, 2002, that:

(1) is not purchased from an insurance company or financial institution that is subject to licensing or regulation by the Minnesota Department of Commerce or a similar regulatory agency of another state;

(2) does not pay out principal and interest in equal monthly installments; or

(3) does not begin payment at the earliest possible date after annuitization.

(f) Transfers under this section shall affect determinations of eligibility for all medical assistance services or long-term care services, whichever receives federal approval.

Subd. 2b. **Period of ineligibility.** (a) Notwithstanding any contrary provisions of this section, this subdivision applies to transfers, including transfers to trusts, involving recipients of medical assistance that are made on or after July 1, 2003, and to all transfers involving persons who apply for medical assistance on or after July 1, 2003, regardless of when the transfer occurred, except that this subdivision does not apply to transfers made prior to July 1, 2003. For any uncompensated transfer occurring within 72 months prior to the date of application, at any time after application, or while eligible, the number of months of cumulative ineligibility for medical assistance services shall be the total uncompensated value of the assets and income transferred divided by the statewide average per-person nursing facility payment made by the state in effect at the time a penalty for a transfer is determined. The amount used to calculate the average per-person nursing facility payment shall be adjusted each July 1 to reflect average payments for the previous calendar year. For applicants, the period of ineligibility begins with the month in which the person applied for medical assistance and satisfied all other requirements for eligibility, or the first month the local agency becomes aware of the transfer and can give proper notice, if later. For recipients, the period of ineligibility begins in the first month after the month the agency becomes aware of the transfer and can give proper notice, except that penalty periods for transfers made during a period of ineligibility as determined under this section shall begin in the month following the existing period of ineligibility. If the transfer was not reported to the local agency, and the applicant received medical assistance services during what would have been the period of ineligibility if the transfer had been reported, a cause of action exists against the transferee for the cost of medical assistance services provided during the period of ineligibility or for the uncompensated amount of the transfer that was not recovered from the transferor through the implementation of a penalty period under this subdivision, whichever is less. Recovery shall include the costs incurred due to the action. The action may be brought by the state or the local agency responsible for providing medical assistance under this chapter. The total uncompensated value is the fair market value of the income or asset at the time it was given away, sold, or disposed of, less the amount of compensation received. No cause of action exists for a transfer unless:

(1) the transferee knew or should have known that the transfer was being made by a person who was a resident of a long-term care facility or was receiving that level of care in the community at the time of the transfer;

(2) the transferee knew or should have known that the transfer was being made to assist the person to qualify for or retain medical assistance eligibility; or

(3) the transferee actively solicited the transfer with intent to assist the person to qualify for or retain eligibility for medical assistance.

(b) If a calculation of a penalty period results in a partial month, payments for medical assistance services shall be reduced in an amount equal to the fraction, except that in calculating the value of uncompensated transfers, if the total value of all uncompensated transfers made in a month not included in an existing penalty period does not exceed $200, then such transfers shall be disregarded for each month prior to the month of application for or during receipt of medical assistance.

(c) Ineligibility under this section shall apply to medical assistance services or long-term care services, whichever receives federal approval.

Subd. 3b. **Homestead exception to transfer prohibition.** (a) This subdivision applies to transfers involving recipients of medical assistance that are made on or after July 1, 2003, and to all transfers involving persons who apply for medical assistance on or after July 1, 2003, regardless of when the transfer occurred, except that this subdivision does not apply to transfers made prior to July 1, 2003. A person is not ineligible for medical assistance services due to a transfer of assets for less than fair market value as described in subdivision 1b, if the asset transferred was a homestead, and:

(1) a satisfactory showing is made that the individual intended to dispose of the homestead at fair market value or for other valuable consideration; or

(2) the local agency grants a waiver of a penalty resulting from a transfer for less than fair market value because denial of eligibility would cause undue hardship for the individual and there exists an imminent threat to the individual's health and well-being. Whenever an applicant or recipient is denied eligibility because of a transfer for less than fair market value, the local agency shall notify the applicant or recipient that the applicant or recipient may request a waiver of the penalty if the denial of eligibility will cause undue hardship. In evaluating a waiver, the local agency shall take into account whether the individual was the victim of financial exploitation, whether the individual has made reasonable efforts to recover the transferred property or resource, and other factors relevant to a determination of hardship. If the local agency does not approve a hardship waiver, the local agency shall issue a written notice to the individual stating the reasons for the denial and the process for appealing the local agency's decision.

(b) When a waiver is granted under paragraph (a), clause (2), a cause of action exists against the person to whom the homestead was transferred for that portion of medical assistance services granted within 72 months of the date the transferor applied for medical assistance and satisfied all other requirements for eligibility or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action. The action shall be brought by the state unless the state delegates this responsibility to the local agency responsible for providing medical assistance under this chapter.

Subd. 4b. **Other exceptions to transfer prohibition.** This subdivision applies to transfers involving recipients of medical assistance that are made on or after July 1, 2003, and to all transfers involving persons who apply for medical assistance on or after July 1, 2003, regardless of when the transfer occurred, except that this subdivision does not apply to transfers made prior to July 1, 2003. A person or a person's spouse who made a transfer prohibited by subdivision 1b is not ineligible for medical assistance services if one of the following conditions applies:

(1) the assets or income were transferred to the individual's spouse or to another for the sole benefit of the spouse, except that after eligibility is established and the assets have been divided between the spouses as part of the asset allowance under section 256B.059, no further transfers between spouses may be made;

(2) the institutionalized spouse, prior to being institutionalized, transferred assets or income to a spouse, provided that the spouse to whom the assets or income were transferred does not then transfer those assets or income to another person for less than fair market value. At the time when one spouse is institutionalized, assets must be allocated between the spouses as provided under section 256B.059;

(3) the assets or income were transferred to a trust for the sole benefit of the individual's child who is blind or permanently and totally disabled as determined in the supplemental security income program and the trust reverts to the state upon the disabled child's death to the extent the medical assistance has paid for services for the grantor or beneficiary of the trust. This clause applies to a trust established after the commissioner publishes a notice in the State Register that the commissioner has been authorized to implement this clause due to a change in federal law or the approval of a federal waiver;

(4) a satisfactory showing is made that the individual intended to dispose of the assets or income either at fair market value or for other valuable consideration; or

(5) the local agency determines that denial of eligibility for medical assistance services would cause undue hardship and grants a waiver of a penalty resulting from a transfer for less than fair market value because there exists an imminent threat to the individual's health and well-being. Whenever an applicant or recipient is denied eligibility because of a transfer for less than fair market value, the local agency shall notify the applicant or recipient that the applicant or recipient may request a waiver of the penalty if the denial of eligibility will cause undue hardship. In evaluating a waiver, the local agency shall take into account whether the individual was the victim of financial exploitation, whether the individual has made reasonable efforts to recover the transferred property or resource, and other factors relevant to a determination of hardship. If the local agency does not approve a hardship waiver, the local agency shall issue a written notice to the individual stating the reasons for the denial and the process for appealing the local agency's

decision. When a waiver is granted, a cause of action exists against the person to whom the assets were transferred for that portion of medical assistance services granted within 72 months of the date the transferor applied for medical assistance and satisfied all other requirements for eligibility, or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action. The action shall be brought by the state unless the state delegates this responsibility to the local agency responsible for providing medical assistance under this chapter.

Subd. 5. **Notice of receipt of federal waiver.** In every instance in which a federal waiver that allows the implementation of a provision in this section is granted, the commissioner shall publish notice of receipt of the waiver in the State Register.